PASRR REQUEST FOR RECONSIDERATION

If you wish to discuss the recommendations included in the Department of Health Care Services (DHCS) PASRR Determination, please complete this request form and submit to DHCS.

Resident's Name:	PASRR Client Identification Number (CID#):
Facility Name and Address:	
Name of Conservator (If applicable):	Telephone Number:
I am a:	Reason for my request is:
◯ Resident ◯ Facility Staff ◯ Family/Conservator/Other My relationship to the resident is: _____	☐ I am requesting a Reconsideration on the recommendations in the Determination ☐ There was an error in the Determination ☐ I have another concern with the Determination
Please describe your request:	What outcome would you like:
Information of Individual Completing the Form	
Printed Name:	Telephone Number:
Signature:	Date:
Mail to: **Department of Health Care Services** **Clinical Assurance and Administrative Support Division (CAASD), PASRR Section** **P.O. Box 997419 MS 4506** **Sacramento, CA 95899-7419**	**Fax to:** **(916) 319-0980**